State of Wisconsin
2013 – 2014 LEGISLATURE

December 2013 Special Session

LRB–3678/P1
PJK&JK:jld&eev:jf

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT ***to amend*** 20.145 (5) (k), 71.07 (5g) (b), 71.07 (5g) (d) 2., 71.28 (5g) (b), 71.28 (5g) (d) 2., 71.47 (5g) (b), 71.47 (5g) (d) 2., 76.655 (2), 76.655 (5), 177.075 (3), 895.514 (2), 895.514 (3) (a) and 895.514 (3) (b) of the statutes; and ***to affect*** 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. c., 2013 Wisconsin Act 20, section 9122 (1L) (b) 2., 2013 Wisconsin Act 20, section 9122 (1L) (b) 3. a. and c. and 4., 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. (intro.) and 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. a., 9. a., 10. a. and b. and 11. b.; **relating to:** extending the deadline for the dissolution of the Health Insurance Risk–Sharing Plan.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a subsequent version of this draft.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.145 (5) (k) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

20.145 **(5)** (k) *Operational expenses.* All moneys transferred from the appropriation account under par. (g) for operational expenses related to ~~winding up~~ the affairs of the Health Insurance Risk–Sharing Plan, including hiring consultants, limited–term employees, and experts.

SECTION 2. 71.07 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.02 an amount that is equal to the amount of the assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 3. 71.07 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 4. 71.28 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s.

71.23 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 5. 71.28 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 6. 71.47 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.43 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 7. 71.47 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 8. 76.655 (2) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

76.655 **(2)** FILING CLAIMS. Subject to the limitations provided under this section, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the fees imposed under ss. 76.60, 76.63, 76.65, 76.66 or 76.67 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under sub. (3).

SECTION 9. 76.655 (5) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

76.655 **(5)** SUNSET. No credit may be claimed under this section for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this section for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 10. 177.075 (3) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

177.075 **(3)** Any intangible property distributable in the course of the dissolution of the Health Insurance Risk–Sharing Plan under 2013 Wisconsin Act 20, section 9122 (1L), and 2013 Wisconsin Act .... (this act), section 20 (1) (b), is presumed abandoned as otherwise provided under this chapter if sub. (1) (a), (b), or (c) does not apply with respect to the distribution.

SECTION 11. 895.514 (2) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(2)** No cause of action of any nature may arise against, and no liability may be imposed upon, the authority, plan, or board; or any agent, employee, or director of any of them; or insurers participating in the plan; or the commissioner; or any agent, employee, or representative of the commissioner, for any act or

omission by any of them in the performance of their powers and duties under ch. 149, 2011 stats., ~~or~~ under 2013 Wisconsin Act 20, section 9122 (1L), or under 2013 Wisconsin Act .... (this act), section 20 (1) (b), unless the person asserting liability proves that the act or omission constitutes willful misconduct.

SECTION 12. 895.514 (3) (a) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(3)** (a) Except as provided in 2013 Wisconsin Act 20, section 9122 (1L), and 2013 Wisconsin Act .... (this act), section 20 (1) (b), neither the state nor any political subdivision of the state nor any officer, employee, or agent of the state or a political subdivision acting within the scope of employment or agency is liable for any debt, obligation, act, or omission of the authority.

SECTION 13. 895.514 (3) (b) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(3)** (b) All of the expenses incurred by the authority, or the commissioner, or any agent, employee, or representative of the commissioner, in exercising its duties and powers under ch. 149, 2011 stats., ~~or~~ under 2013 Wisconsin Act 20, section 9122 (1L), or under 2013 Wisconsin Act .... (this act), section 20 (1) (b), shall be payable only from funds of the authority or from the appropriation under s. 20.145 (5) (g) or (k), or from any combination of those payment sources.

SECTION 14. 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b. is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 1. b. Except as provided in 2013 Wisconsin Act .... (this act), section 20 (1) (b) 1. a. to c., coverage under the policies issued under the plan, including to persons whose coverage under the plan is funded under a contract with the federal department of health and human services,

terminates at 11:59 p.m. on December 31, 2013. At least 60 days before coverage terminates, the authority shall provide notice of the date on which coverage terminates to all covered persons, all insurers and providers that are affected by the termination of the coverage, the office, the legislative audit bureau, and the insurers described in subsection (1m) (b) 1.

SECTION 15. 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. c. is repealed.

SECTION 16. 2013 Wisconsin Act 20, section 9122 (1L) (b) 2. is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 2. 'Provider claims.' Providers of medical services and devices and prescription drugs to covered persons must file claims for payment no later than June 1, 2014. Any claim filed after that date is not payable and may not be charged to the covered person who received the service, device, or drug. Except for copayments, coinsurance, or deductibles required under the plan, consistent with sections 149.14 (3) and 149.142 (2m) of the statutes, a provider may not bill a covered person who receives a covered service or article and shall accept as payment in full the payment rate determined under section 149.142 (1) of the statutes.

****NOTE: You can't mix filing and receiving. Which do you want, that the claims must be filed or received on June 1, 2014? I have retained the "filed" language from Act 20.

SECTION 17. 2013 Wisconsin Act 20, section 9122 (1L) (b) 3. a. and c. and 4. are amended to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 3. a. Except as provided in 2013 Wisconsin Act .... (this act), section 20 (1) (b) 3. a., except for a grievance related to a prior authorization denial, a covered person must submit any grievance, in writing,

no later than 180 days after the date coverage terminates under subdivision 1. b. or be barred from submitting the grievance.

c. ~~A~~ Except as provided in 2013 Wisconsin Act .... (this act), section 20 (1) (b) 3. b., a covered person who submits a grievance after the date coverage terminates under subdivision 1. b. must request an independent review, if any, with respect to the grievance no later than 60 days after he or she receives notice of the disposition of the grievance or be barred from requesting an independent review with respect to the grievance.

4. 'Payment of plan costs.' ~~The~~ Except as provided in 2013 Wisconsin Act .... (this act), section 20 (1) (b) 4. b., to the extent possible, the authority shall pay plan costs incurred in 2013 and all other costs associated with dissolving the plan that are incurred before administrative responsibility for the dissolution of the plan is transferred to the office under subdivision 8. The authority and the office shall make every effort to pay plan costs in accordance with, or as closely as possible to, the manner provided in section 149.143 of the statutes.

SECTION 18. 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. (intro.) is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 8. 'Transfer to the office.' (intro.) On February 28, 2014, all of the following shall occur:

SECTION 19. 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. a., 9. a., 10. a. and b. and 11. b. are amended to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 8. a. Administrative responsibility for the operations and dissolution of the plan is transferred to the office. The commissioner shall take any action necessary or advisable to manage and wind up the affairs of the plan and shall notify the legislative audit bureau when the

windup is completed and provide to the legislative audit bureau the final financial statements of the plan. For purposes of chapter 177 of the statutes, as affected by this act, the dissolution, and winding up of the affairs, of the plan shall be considered a dissolution of an insurer in accordance with section 645.44 of the statutes, except that a court order of dissolution is not required to effect the dissolution of the plan.

9. a. There is created, ~~60 days after the date coverage under the plan terminates under subdivision 1. b.~~ on March 1, 2014, a Health Insurance Risk–Sharing Plan advisory committee consisting of the commissioner, or his or her designee, and the other 13 members of the board holding office on the date the advisory committee is created.

10. a. On behalf of the commissioner, the authority shall provide notice of the plan's dissolution to all persons known, or reasonably expected from the plan's records, to have claims against the plan, including all covered persons. The notice shall be sent by first class mail to the last–known addresses at least 60 days before the date on which coverage terminates under subdivision 1. b., or as provided in 2013 Wisconsin Act .... (this act), section 20 (1) (b) 5. a. Notice to potential claimants of the plan shall require the claimants to file their claims, together with proofs of claims, ~~within 90 days after the date on which coverage terminates under subdivision 1. b.~~ by June 1, 2014. The notice shall be consistent with any relevant terms of the policies under the plan and contracts and with section 645.47 (1) (a) of the statutes. The notice shall serve as final notice consistent with section 645.47 (3) of the statutes.

b. Proofs of all claims must be filed with the office in the form provided by the office consistent with the proof of claim, as applicable, under section 645.62 of the statutes, on or before the last day for filing specified in the notice. For good cause shown, the office shall permit a claimant to make a late filing if the existence of the

claim was not known to the claimant and the claimant files the claim within 30 days after learning of the claim, but not ~~more than 210 days after the date on which coverage terminates under subdivision 1. b.~~ later than September 1, 2014. Any such late claim that would have been payable under the policy under the plan if it had been filed timely and that was not covered by a succeeding insurer shall be permitted unless the claimant had actual notice of the termination of the plan or the notice was mailed to the claimant by first class mail at least 10 days before the insured event occurred.

11. b. Complete a final audit of the plan, after the termination of the plan in 2014, ~~within 90 days after the office provides the final financial statements of the plan under subdivision 8. a.~~ by June 30, 2015.

SECTION 20. Nonstatutory provisions.

(1) COVERAGE EXTENSION OF THE HEALTH INSURANCE RISK-SHARING PLAN; ISSUANCE OF MEDICARE SUPPLEMENT AND REPLACEMENT POLICIES.

(a) *Definitions.* In this subsection:

1. "Authority" means the Health Insurance Risk–Sharing Plan Authority under subchapter III of chapter 149 of the statutes.

2. "Commissioner" means the commissioner of insurance.

3. "Covered person" means a person who has coverage under the plan.

4. "Medicare" has the meaning given in section 149.10 (7) of the statutes.

5. "Medicare Advantage" has the meaning given in section INS 3.39 (3) (r), Wisconsin Administrative Code.

6. "Medicare replacement policy" has the meaning given in section 600.03 (28p) of the statutes.

7. "Medicare supplement policy" has the meaning given in section 600.03 (28r) of the statutes.

8. "Office" means the office of the commissioner of insurance.

9. "Plan" means the Health Insurance Risk–Sharing Plan under subchapter II of chapter 149 of the statutes.

(b) *Extension of the plan and authority.* Notwithstanding any statute, administrative rule, or provision of a policy or contract or of the plan to the contrary, the dissolution of the plan and the authority as provided in 2013 Wisconsin Act 20, section 9122 (1L), is modified as follows:

1. 'Coverage provisions.' Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., are of the following apply:

a. A covered person whose coverage under the plan was in effect on December 1, 2013, and who paid his or her December premium may elect to obtain a policy under the plan by making a timely payment of the January 2014 premium. The covered person must maintain the same policy benefits, including the same deductible amount, that were in effect on December 1, 2013. A new deductible period will commence on January 1, 2014. The premium for January 2014 must be paid no later than February 1, 2014. Thereafter, the covered person must pay premiums in accordance with the terms of the contract for coverage, which may not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the covered person incurs after December 31, 2013, and before the plan receives the premium payment for January 2014 shall be held in abeyance and the plan shall not be responsible for payment.

****NOTE: I used "held in abeyance" instead of "pended." Will the plan pay for these claims after the premium is received? If so, it should be stated "until premium payment is received."

b. If a covered person's coverage under the plan is funded under a contract with the federal department of health and human services, the covered person's coverage will end as provided in 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., unless the federal department of health and human services issues a contract amendment that extends the contract and coverage to a date later than December 31, 2013, and the terms of the contract amendment are such that the federal government will be financially liable for all costs related to the operation of the contract that exceed member premium collections.

c. If the requirements under subdivision 1. b. are satisfied, a covered person whose coverage is funded under a contract with the federal department of health and human services, whose coverage under the plan was in effect on December 1, 2013, who paid his or her December premium, and who had not enrolled in Medicare Advantage during the federal open enrollment period in 2013 or earlier may elect to obtain a policy under the plan by making a timely payment of the January 2014 premium. The covered person must maintain the same policy benefits, including the same deductible amount, that were in effect on December 1, 2013. A new deductible period will commence on January 1, 2014. The premium for January 2014 must be paid no later than February 1, 2014. Thereafter, the covered person must pay premiums in accordance with the terms of the contract for coverage, which may not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the covered person incurs after December 31, 2013, and before the plan receives the premium payment for January 2014 shall be held in abeyance and the plan shall not be responsible for payment.

****NOTE: I used "held in abeyance" instead of "pended." Will the plan pay for these claims after the premium is received? If so, it should be stated "until premium payment is received."

****NOTE: "During the open enrollment period in 2013 or earlier" is a bit vague. Is that limited to earlier *in 2013*?

d. No later than February 1, 2014, the authority shall provide notice that coverage shall terminate on March 31, 2014, to all covered persons, all insurers and providers that are affected by the termination of the coverage, the office, the legislative audit bureau, and the insurers described in paragraph (c) 1.

****NOTE: I thought it would be more relevant to the insurers in paragraph (c) in this subsection than to the insurers described in Act 20, section 9122(1m)

2. 'Provider claims.' Any claim for payment from a provider of medical services and devices and prescription drugs to a covered person whose coverage is extended as provided in this paragraph must be filed no later than June 1, 2014. Any claim filed after that date is not payable and may not be charged to the covered person who received the service, device, or drug. Except for copayments, coinsurance, or deductibles required under the plan, consistent with sections 149.14 (3) and 149.142 (2m) of the statutes, a provider may not bill a covered person who receives a covered service or article and shall accept as payment in full the payment rate determined under section 149.142 (1) of the statutes.

File claims for payment

****NOTE: I limited this to claims for services, etc., provided to persons whose coverage is extended, or it would not make sense to include this here since it is the same as when claims must be filed for persons whose coverage is not extended under Act 20, as amended by this bill. Note that I required claims to be filed rather than received by June 1, 2014.

Insert 12-13

3. 'Grievances and review.'

a. Any grievance by a covered person whose coverage is extended as provided in this paragraph must be in writing and received by the plan no later than July 1, 2014, or be barred.

Notwithstanding 2013 Wisconsin Act 20, section 9122(1L)(b)3.a., letter

b. A covered person whose coverage is extended as provided in this paragraph who submits a grievance after March 31, 2014, must request an independent review,

Notwithstanding 2013 Wisconsin Act 20, section 9122(1L)(b)3.b.,

Insert 12-17

if any, with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review with respect to the grievance.

4. 'Payment of plan costs.'

a. To the extent possible, the authority shall pay plan costs incurred in 2013 and 2014 and all other costs associated with operating and dissolving the plan that are incurred before administrative responsibility for the dissolution of the plan is transferred to the office on February 28, 2014.

****NOTE: I removed the language about "requirements are met as provided in subsection (1L) (b) 8." because I didn't know what requirements were being referred to and what the relationship was to the rest of the sentence. If you want some language back in, please clarify the meaning.

b. The authority, before March 1, 2014, and the office, on and after March 1, 2014, shall pay plan costs in the manner provided in section 149.143 of the statutes, except that the authority or office may use all available surplus before imposing an assessment against insurers, as described in subdivision 4. c. All claims shall be adjudicated on or before September 30, 2014.

c. The authority, before March 1, 2014, and the office, on and after March 1, 2014, but by no later than July 1, 2014, shall determine whether an assessment of insurers under section 149.13 of the statutes is necessary to cover in full the plan's expenses related to operations, winding up operations, and dissolution of the plan. Such assessment shall be based on the 2013 filed plan assessment form.

5. 'Dissolution notice, claims, and updates.'

a. On behalf of the commissioner, the authority shall provide notice of the plan's dissolution to all persons known, or reasonably expected from the plan's records, to have claims against the plan, including all covered persons. The notice shall be sent by 1st class mail to the last–known addresses no later than February 1, 2014. Notice to potential claimants of the plan shall require the claimants to file their claims,

together with proofs of claims, by June 1, 2014. The notice shall be consistent with any relevant terms of the policies under the plan and contracts and with section 645.47 (1) (a) of the statutes. The notice shall serve as final notice consistent with section 645.47 (3) of the statutes.

b. Proofs of all claims must be filed with the office in the form provided by the office consistent with the proof of claim, as applicable, under section 645.62 of the statutes, on or before the last day for filing specified in the notice. For good cause shown, the office shall permit a claimant to make a late filing if the existence of the claim was not known to the claimant and the claimant files the claim within 30 days after learning of the claim, but not later than September 1, 2014. Any such late claim that would have been payable under the policy under the plan if it had been filed timely and that was not covered by a succeeding insurer shall be permitted unless the claimant had actual notice of the termination of the plan or the notice was mailed to the claimant by 1st class mail at least 10 days before the insured event occurred.

****NOTE: Should this be limited to persons who extend coverage? This is the same as under Act 20, as amended. Why are two identical provisions necessary?

(c) *Medicare supplement and replacement policy issuance.*

****NOTE: Are the people affected by this provision the same people described in paragraph (b) 1. b. and c. above? If so, all that is needed are the following provisions. I removed the proposed subdivision extending their HIRSP coverage because it is not needed. Coverage has already been extended under paragraph (b) 1. b. and c. above. The provision in Act 20 that is similar to this was intended for the purpose of guaranteeing issue under Medicare supplement and replacement policies to persons eligible for Medicare whose coverage under HIRSP was ending. It was separate from the provisions related to terminating coverage under HIRSP and so this paragraph should not include any HIRSP coverage extension. If I am mistaken and the people to whom this paragraph applies are not the same people described in paragraph (b) 1. b. and c. above, please let me know. There is no description of individuals in Act 20's subsection (1m) (b), as the proposed language suggested.

1. In addition to the requirement under 2013 Wisconsin Act 20, section 9122 (1m), an insurer offering a Medicare supplement policy or a Medicare replacement

policy in this state shall provide coverage under the policy to any individual who satisfies all of the following:

a. The individual is eligible for Medicare.

b. The individual had coverage under the plan.

****NOTE: It should not be necessary to specify that the individual had coverage on December 1, 2013, because that is a requirement for extended coverage that ends on March 31, 2014, as provided in subdivision 1. c. below.

c. The individual's coverage under the plan terminated on March 31, 2014.

d. The individual applies for coverage under the policy before 63 days after the date specified in subdivision 1. c.

e. The individual pays the premium for the coverage under the policy.

2. An insurer under subdivision 1. may not deny coverage to any individual who satisfies the criteria under subdivision 1. a. to e. on the basis of health status, receipt of health care, claims experience, or medical condition including disability.

3. In addition to any other notice requirements to insurers, no later than February 1, 2014, the authority shall provide notice to the insurers described in subdivision 1. of the requirements under this paragraph.

SECTION 21. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTH INSURANCE RISK-SHARING PLAN. The treatment of section 895.514 (2) and (3) (a) and (b) of the statutes takes effect on January 1, 2015.

(END)

d-note

2013–2014 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–3678/P1ins
PJK:...:...

INSERT 12–13

****NOTE: I required claims to be filed, rather than received, by June 1, 2014. Please change this to received if that is what you intend. Since the date for filing is the same as for claims for services provided to persons whose coverage is not extended, I did not limit the claims to those for services provided after coverage is extended.

(END OF INSERT 12–13)

INSERT 12–17

****NOTE: Since the date for submitting a grievance is extended for a person whose coverage is extended, do you want to limit the types of grievances that may be submitted up to that date, such as grievances arising after December 31, 2013?

(END OF INSERT 12–17

INSERT 13–12

****NOTE: I added "for payment" after claims. By "all claims," I assume they include provider claims. If not, please clarify which claims are being referred to.

(END OF INSERT 13–12)

INSERT 13–17

****NOTE: Does just the determination have to be made, or does any assessment have to be imposed by no later than July 1, 2014?

(END OF INSERT 13–17)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3678/2dn
PJK:~~cjf~~

date

I've made a number of modifications to the proposed language. Please review the language carefully to make sure I haven't removed something that you feel is needed because it didn't make sense to me or because I imposed an interpretation that was not what you intended.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3678/P1dn
PJK:jld:jf

November 22, 2013

I've made a number of modifications to the proposed language. Please review the language carefully to make sure I haven't removed something that you feel is needed because it didn't make sense to me or because I imposed an interpretation that was not what you intended.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

Kahler, Pam

From: Walsh, Julie E - OCI <Julie.Walsh@wisconsin.gov>
Sent: Friday, November 22, 2013 4:43 PM
To: Kahler, Pam
Cc: Schwartzer, Dan - OCI; Goldman, Amie - HIRSP
Subject: Fwd: Draft review: LRB -3678/P1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus

Pam

Below are the comments from Ici and HIRSP. I do not have an answer on the tax credit yet.

Julie E. Walsh
Senior Attorney
Wisconsin Office of the Commissioner of Insurance
Julie.Walsh@wisconsin.gov
Ph: (608)264-8101
Fax (608)264-6228
Mobil (608)417-0281

****CONFIDENTIAL********
This communication is intended to be transmitted to or from the OCI legal unit and may contain information that is privileged, confidential and protected by the attorney-client, attorney work product or s. 601.465, Wis. Stat., privileges.

Begin forwarded message:

> **From:** "Goldman, Amie - HIRSP" <AGoldman@hirsp.org>
> **Date:** November 22, 2013 at 4:33:24 PM CST
> **To:** "Walsh, Julie E - OCI" <Julie.Walsh@wisconsin.gov>
> **Subject: RE: Draft review: LRB -3678/P1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus**
>
> Hi Julie – I agree with everything you noted including the need to keep the Medicare language to create the special enrollment period. I just had one clarification and one change, which are noted in red below. Do you want me to follow-up with Pam or is there still time to incorporate them with your answers? Thanks.

Begin forwarded message:

> **From:** "Walsh, Julie E - OCI" <Julie.Walsh@wisconsin.gov>
> **Date:** November 22, 2013 at 2:51:28 PM CST
>
> On Nov 22, 2013, at 2:46 PM, "Walsh, Julie E - OCI" <Julie.Walsh@wisconsin.gov> wrote:
>
> Dan my proposed responses to the questions:

Page 6, line 16 Please use "filed"

Page 10 line 10 Please add "until premium payment is received"

Page 11 line 10 first comment Please add "until premium payment is received"

Page 11 line 10 second comment Please redraft to read "During the open enrollment period in 2013" delete "or earlier"

Page 11 line 14 Change proposed is fine as drafted

Page 12 line 2 Please use "filed" and your assumption is correct

Page 12 line 7 We are moving all grievances to one date at HIRSP request for simplicity. Therefore, we need to repeal and recreate 1(L)(b)(3) to reflect that the new dates for grievances as you did in your draft.

take out "notwithstanding" and make 3.a. + c. like new 3.a + b.? no change to old b.?

yes

Page 12 line 17 Change proposed is fine as drafted yes you can delete language

Page 13 line 4 Change proposed is fine as drafted – yes claims include provider claims. It should say "provider claims" rather than "claims for payment" because we will have administrative claims that come in for payment after 9/30 that are paid of the Accounts Payable.

Page 13 line 9 Please use "determination" for greatest flexibility

Page 14 line 9 These are different people, the Medicare eligible persons - we are keeping similar requirements for the 3 different groups of HIRSP members (regular, federal funded, and Medicare eligible) so I paralleled Act 20 format by retaining the discussion of the Medicare members within their own section. The key for this group is not having applied for Medicare Advantage as that replaces Medicare Parts A and B and then the insurers can't wrap around Medicare. We do

added med advan to 1.a.

still want to guarantee issue Med supp for this group but wanted to set their requirements up uniquely. Please let me know if I can help further clarify.

✓ Page 14 line 15 drafted. Change proposed is fine as

Julie E. Walsh
Senior Attorney
Office of the Commissioner of Insurance
Phone: (608) 264-8101
Fax: (608) 264-6228

From: Schwartzer, Dan - OCI
Sent: Friday, November 22, 2013 2:19 PM
To: Walsh, Julie E - OCI
Subject: Re: Draft review: LRB -3678/P1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus

Yes, please forward answers to me and when we have all the answers, we can reply right back to Pam.

THanks
Dan

Sent from my iPad

On Nov 22, 2013, at 2:09 PM, "Walsh, Julie E - OCI" <Julie.Walsh@wisconsin.gov> wrote:

> I assume you have seen this and I will work on answers and forward to JP, Mollie and you.
>
> Julie E. Walsh
> Senior Attorney
> Office of the Commissioner of Insurance
> Phone: (608) 264-8101
> Fax: (608) 264-6228
>
> ---
>
> **From:** Wieske, JP - OCI
> **Sent:** Friday, November 22, 2013 2:02 PM
> **To:** Walsh, Julie E - OCI; Zito, Mollie K - OCI

Cc: Schwartzer, Dan - OCI; Hurlburt, Waylon - GOV
Subject: Fwd: Draft review: LRB - 3678/P1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus

Mollie and Julie

Please review ASAP.

Thanks!

JP.

J.P. Wieske, FLMI
Legislative Liaison & Public Information Officer
Office of the Commissioner of Insurance
jpwieske@wisconsin.gov
(608) 266-2493

Begin forwarded message:

> **From:** "Hurlburt, Waylon - GOV" <Waylon.Hurlburt@wisconsin.gov>
> **Date:** November 22, 2013 at 1:18:41 PM CST
> **To:** "Schwartzer, Dan - OCI" <Dan.Schwartzer@wisconsin.gov>, "Wieske, JP - OCI" <JP.Wieske@wisconsin.gov>
> **Cc:** "Kahler, Pam - LEGIS" <Pam.Kahler@legis.wisconsin.gov>
> **Subject: FW: Draft review: LRB - 3678/P1 Topic: Delay for three months the**

dissolution of HIRSP and the changes to BadgerCare Plus

Dan and J.P.,

Can you please reply to Pam with answers to her drafter's notes in the Pdraft as soon as possible? We need to get a final draft done soon and combine it with the Medicaid changes.

Thanks.

Waylon Hurlburt

Policy Director

The Office of Governor Scott Walker

State of Wisconsin

(608)266-9709

From: LRB.Legal [mailto:lrblegal@legis.wisconsin.gov]
Sent: Friday, November 22, 2013 12:54 PM
To: Hurlburt, Waylon - GOV
Subject: Draft review: LRB -3678/P1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus

Following is the PDF version of draft LRB -3678/P1 and drafter's note.

<13-3678_P1.pdf>

<13-3678_P1dn.pdf>

Kahler, Pam

From: Hurlburt, Waylon - GOV <Waylon.Hurlburt@wisconsin.gov>
Sent: Monday, November 25, 2013 9:58 AM
To: Kahler, Pam; Dodge, Tamara
Subject: FW: Special Session Drafts

OCI is comfortable with the below language being added related to the tax credit. Please add.

Thanks.

Waylon

From: Schwartzer, Dan - OCI
Sent: Monday, November 25, 2013 9:48 AM
To: Hurlburt, Waylon - GOV; Wieske, JP - OCI; Zito, Mollie K - OCI
Cc: Schutt, Eric - GOV; Polzin, Cindy M - GOV; Zipperer, Rich - GOV; Ziegler, Paul - DOA; Heifetz, Michael G - DOA
Subject: RE: Special Session Drafts

Hi,

I think we agree with some of what SBO came up with. Below is our opinion on the solution. Let me know your thoughts and if the budget shop should draft or if you want us to start drafting the provision. If more questions arise from this, please let us know so we can reach back to Fred Thorton.

Thanks

Dan

Fred Thornton (who is our tax expert in our financial division) is also confident that if we cap the available credit in 2014 to 1.25 million on a pro rata basis there should be no impact on GPR. I can draft the language to amend s. 71.28 (5g) (c) 1. – to create a 1m. that would limit the credit just for tax year 2014.

From: Hurlburt, Waylon - GOV
Sent: Friday, November 22, 2013 4:10 PM
To: Wieske, JP - OCI; Walsh, Julie E - OCI; Zito, Mollie K - OCI; Schwartzer, Dan - OCI
Cc: Schutt, Eric - GOV; Polzin, Cindy M - GOV; Zipperer, Rich - GOV; Ziegler, Paul - DOA; Heifetz, Michael G - DOA
Subject: FW: Special Session Drafts

J.P.,

Below is the suggested change from SBO. If you are ok with it please have Pam Kahler from LRB add to the HIRSP draft so we can get this tied up on Monday.

Thank you.

Waylon

From: Ziegler, Paul - DOA
Sent: Friday, November 22, 2013 3:57 PM
To: Hurlburt, Waylon - GOV
Cc: Grinde, Kirsten - DOA; Heifetz, Michael G - DOA
Subject: FW: Special Session Drafts

Waylon – To limit the potential fiscal impact, we may wish to flag the following to the LRB and OCI:

The $5 million factor which is used in determining the % of the assessments that are eligible for the HISRP assessment credit may need to be prorated from $5 million to $1.25 million for the Jan-March 2014 period (as specified under s.71.28(5g)(c)1, s.71.28(5g)(c)1., s.71.47(5g) (c)1., and under 76.665 (3)(a) to ensure that the proration factor remains appropriate relative to prior years.

While we have NOT given this detailed research, in absence of such a change, the fiscal impact for the 3 month extension under the credit may equal that as if it were a 12 month extension.

The credit is capped at $5 million annually. Without any change suggested above, the 3 month impact could approach this level rather than one-fourth of this amount.

Paul

From: Quinn, Brian D - DOA
Sent: Friday, November 22, 2013 3:43 PM
To: Ziegler, Paul - DOA
Subject: RE: Special Session Drafts

Paul,

Here's my concern about the draft in its present form.

The credit is equal to the amount of the assessment paid under s. 149.13 multiplied by the percentage proration factor. Expressed algebraically:

C = Credit
A = Assessment
P = Percentage Proration Factor

C = A x P

P in this case is equal to $5 million divided by the total amount of assessments (sum of A for all participating insurers) determined under s. 149.13. That statute reads thusly:

"149.13 Participation of insurers.
(1) Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under sub. (2) would be so minimal as to not exceed the estimated cost of levying the assessment. The commissioner shall advise the authority of the insurers participating in the cost of administering the plan.
(2) Every participating insurer shall share in the operating, administrative and subsidy expenses of the plan in proportion to the ratio of the insurer's total health care coverage revenue for residents of this state during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year, as determined by the commissioner.
(3)

(a) Each insurer's proportion of participation under sub. (2) shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner. The commissioner shall assess an insurer for the insurer's proportion of participation based on the total assessments estimated by the authority. An insurer shall pay the amount of the assessment directly to the authority."

My initial reading of it is that the assessments under s. 149.13 will decline since it will only be around for a quarter of a year. However, all that will happen is that the percentage P will increase since $5 million simply gets divided into a smaller number. Therefore, we will still be on the hook for up to $5 million for only a quarter year of coverage.

Conclusion: For determining the percentage in the 2014 tax year, the calculation shall be $1,250,000 divided by aggregate assessments in 2014 under s. 149.13.

Brian Quinn
Executive Policy and Budget Analyst - Senior
Wisconsin Department of Administration
Division of Executive Budget and Finance
(608)-266-1923
Brian.quinn@wisconsin.gov

From: Ziegler, Paul - DOA
Sent: Friday, November 22, 2013 3:28 PM
To: Quinn, Brian D - DOA
Subject: FW: Special Session Drafts

From: Hurlburt, Waylon - GOV
Sent: Friday, November 22, 2013 1:20 PM
To: Heifetz, Michael G - DOA; Polzin, Cindy M - GOV; Schutt, Eric - GOV; Zipperer, Rich - GOV; Hoelter, Jon - GOV
Cc: Suhr, Daniel R - GOV
Subject: RE: Special Session Drafts

Attached is the HIRSP Pdraft. There are numerous drafter questions. I sent them to JP and Dan to work on those with the drafter.

DHS told me they were getting back to the drafter on the Medicaid portion today and the drafter was working the weekend to get it done.

Waylon

From: Hurlburt, Waylon - GOV
Sent: Thursday, November 21, 2013 12:04 PM
To: Heifetz, Michael G - DOA; Polzin, Cindy M - GOV; Schutt, Eric - GOV; Zipperer, Rich - GOV; Hoelter, Jon - GOV
Cc: Suhr, Daniel R - GOV
Subject: Special Session Drafts

Attached is the preliminary draft for the Medicaid changes and the drafting instructions from OCI for the HIRSP changes.

DHS is answering the drafters questions on Medicaid draft and LRB hasn't sent a preliminary draft on HIRSP yet. The idea is that when we are good with both drafts, they will combine them under the same LRB numbers into the Senate and Assembly versions.

I will forward any updated drafts when I get them.

Waylon Hurlburt

Policy Director

The Office of Governor Scott Walker

State of Wisconsin

(608)266-9709

State of Wisconsin
2013 – 2014 LEGISLATURE

December 2013 Special Session

LRB-3678/P1
PJK&JK:~~jld/kjf/eev/cjs~~

2013 BILL minimum + TJD

~~PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION~~

jld/kjf/eev/cjs

Now

requirements

AN ACT ***to amend*** 20.145 (5) (k), 71.07 (5g) (b), 71.07 (5g) (d) 2., 71.28 (5g) (b), 71.28 (5g) (d) 2., 71.47 (5g) (b), 71.47 (5g) (d) 2., 76.655 (2), 76.655 (5), 177.075 (3), 895.514 (2), 895.514 (3) (a) and 895.514 (3) (b) of the statutes; and ***to affect*** 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. c., 2013 Wisconsin Act 20, section 9122 (1L) (b) 2., 2013 Wisconsin Act 20, section 9122 (1L) (b) 4., 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. (intro.) and 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. a., 9. a., 10. a. and b. and 11. b.; **relating to:** extending coverage under, and the deadline for the dissolution of, the Health Insurance Risk–Sharing Plan.

Insert rel-TJD

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a subsequent version of this draft.

Insert analysis-TJD

Insert A-PJK

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.145 (5) (k) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

20.145 **(5)** (k) *Operational expenses.* All moneys transferred from the appropriation account under par. (g) for operational expenses related to ~~winding up~~ the affairs of the Health Insurance Risk–Sharing Plan, including hiring consultants, limited–term employees, and experts.

SECTION 2. 71.07 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.02 an amount that is equal to the amount of the assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 3. 71.07 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 4. 71.28 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s.

71.23 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 5. 71.28 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 6. 71.47 (5g) (b) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (b) *Filing claims.* Subject to the limitations provided under this subsection, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the taxes imposed under s. 71.43 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under par. (c) 1.

SECTION 7. 71.47 (5g) (d) 2. of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (d) 2. No credit may be claimed under this subsection for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this subsection for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 8. 76.655 (2) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

76.655 **(2)** FILING CLAIMS. Subject to the limitations provided under this section, for taxable years beginning after December 31, 2005, and before January 1, ~~2014~~ 2015, a claimant may claim as a credit against the fees imposed under ss. 76.60, 76.63, 76.65, 76.66 or 76.67 an amount that is equal to the amount of assessment under s. 149.13, 2011 stats., that the claimant paid in the claimant's taxable year, multiplied by the percentage determined under sub. (3).

SECTION 9. 76.655 (5) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

76.655 **(5)** SUNSET. No credit may be claimed under this section for taxable years beginning after December 31, ~~2013~~ 2014. Credits under this section for taxable years that begin before January 1, ~~2014~~ 2015, may be carried forward to taxable years that begin after December 31, ~~2013~~ 2014.

SECTION 10. 177.075 (3) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

177.075 **(3)** Any intangible property distributable in the course of the dissolution of the Health Insurance Risk–Sharing Plan under 2013 Wisconsin Act 20, section 9122 (1L), and 2013 Wisconsin Act .... (this act), section 20 (1) (b), is presumed abandoned as otherwise provided under this chapter if sub. (1) (a), (b), or (c) does not apply with respect to the distribution.

SECTION 11. 895.514 (2) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(2)** No cause of action of any nature may arise against, and no liability may be imposed upon, the authority, plan, or board; or any agent, employee, or director of any of them; or insurers participating in the plan; or the commissioner; or any agent, employee, or representative of the commissioner, for any act or

omission by any of them in the performance of their powers and duties under ch. 149, 2011 stats., ~~or~~ under 2013 Wisconsin Act 20, section 9122 (1L), or under 2013 Wisconsin Act .... (this act), section 20 (1) (b), unless the person asserting liability proves that the act or omission constitutes willful misconduct.

SECTION 12. 895.514 (3) (a) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(3)** (a) Except as provided in 2013 Wisconsin Act 20, section 9122 (1L), and 2013 Wisconsin Act .... (this act), section 20 (1) (b), neither the state nor any political subdivision of the state nor any officer, employee, or agent of the state or a political subdivision acting within the scope of employment or agency is liable for any debt, obligation, act, or omission of the authority.

SECTION 13. 895.514 (3) (b) of the statutes, as created by 2013 Wisconsin Act 20, is amended to read:

895.514 **(3)** (b) All of the expenses incurred by the authority, or the commissioner, or any agent, employee, or representative of the commissioner, in exercising its duties and powers under ch. 149, 2011 stats., ~~or~~ under 2013 Wisconsin Act 20, section 9122 (1L), or under 2013 Wisconsin Act .... (this act), section 20 (1) (b), shall be payable only from funds of the authority or from the appropriation under s. 20.145 (5) (g) or (k), or from any combination of those payment sources.

SECTION 14. 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b. is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 1. b. Coverage under the policies issued under the plan, including to persons whose coverage under the plan is funded under a contract with the federal department of health and human services, terminates at 11:59 p.m. on December 31, 2013. At least 60 days before coverage

terminates, the authority shall provide notice of the date on which coverage terminates to all covered persons, all insurers and providers that are affected by the termination of the coverage, the office, the legislative audit bureau, and the insurers described in subsection (1m) (b) 1.

SECTION 15. 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. c. is repealed.

SECTION 16. 2013 Wisconsin Act 20, section 9122 (1L) (b) 2. is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 2. 'Provider claims.' Providers of medical services and devices and prescription drugs to covered persons must file claims for payment no later than June 1, 2014. Any claim filed after that date is not payable and may not be charged to the covered person who received the service, device, or drug. Except for copayments, coinsurance, or deductibles required under the plan, consistent with sections 149.14 (3) and 149.142 (2m) of the statutes, a provider may not bill a covered person who receives a covered service or article and shall accept as payment in full the payment rate determined under section 149.142 (1) of the statutes.

****NOTE: You can't mix filing and receiving. Which do you want, that the claims must be filed or received by June 1, 2014? I have retained the "filed" language from Act 20.

SECTION 17. 2013 Wisconsin Act 20, section 9122 (1L) (b) 4. is amended to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 4. 'Payment of plan costs.' ~~The~~ To the extent possible, the authority shall pay plan costs incurred in 2013 and all other costs associated with dissolving the plan that are incurred before administrative responsibility for the dissolution of the plan is transferred to the office under subdivision 8. The authority and the office shall make every effort to pay

plan costs in accordance with, or as closely as possible to, the manner provided in section 149.143 of the statutes.

SECTION 18. 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. (intro.) is repealed and recreated to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 8. 'Transfer to the office.' (intro.) On February 28, 2014, all of the following shall occur:

SECTION 19. 2013 Wisconsin Act 20, section 9122 (1L) (b) 8. a., 9. a., 10. a. and b. and 11. b. are amended to read:

[2013 Wisconsin Act 20] Section 9122 (1L) (b) 8. a. Administrative responsibility for the operations and dissolution of the plan is transferred to the office. The commissioner shall take any action necessary or advisable to manage and wind up the affairs of the plan and shall notify the legislative audit bureau when the windup is completed and provide to the legislative audit bureau the final financial statements of the plan. For purposes of chapter 177 of the statutes, as affected by this act, the dissolution, and winding up of the affairs, of the plan shall be considered a dissolution of an insurer in accordance with section 645.44 of the statutes, except that a court order of dissolution is not required to effect the dissolution of the plan.

9. a. There is created, ~~60 days after the date coverage under the plan terminates under subdivision 1. b.~~ on March 1, 2014, a Health Insurance Risk–Sharing Plan advisory committee consisting of the commissioner, or his or her designee, and the other 13 members of the board holding office on the date the advisory committee is created.

10. a. On behalf of the commissioner, the authority shall provide notice of the plan's dissolution to all persons known, or reasonably expected from the plan's records, to have claims against the plan, including all covered persons. The notice

shall be sent by first class mail to the last–known addresses at least 60 days before the date on which coverage terminates under subdivision 1. b. Notice to potential claimants of the plan shall require the claimants to file their claims, together with proofs of claims, ~~within 90 days after the date on which coverage terminates under subdivision 1. b.~~ by June 1, 2014. The notice shall be consistent with any relevant terms of the policies under the plan and contracts and with section 645.47 (1) (a) of the statutes. The notice shall serve as final notice consistent with section 645.47 (3) of the statutes.

b. Proofs of all claims must be filed with the office in the form provided by the office consistent with the proof of claim, as applicable, under section 645.62 of the statutes, on or before the last day for filing specified in the notice. For good cause shown, the office shall permit a claimant to make a late filing if the existence of the claim was not known to the claimant and the claimant files the claim within 30 days after learning of the claim, but not ~~more than 210 days after the date on which coverage terminates under subdivision 1. b.~~ later than September 1, 2014. Any such late claim that would have been payable under the policy under the plan if it had been filed timely and that was not covered by a succeeding insurer shall be permitted unless the claimant had actual notice of the termination of the plan or the notice was mailed to the claimant by first class mail at least 10 days before the insured event occurred.

11. b. Complete a final audit of the plan, after the termination of the plan in 2014, ~~within 90 days after the office provides the final financial statements of the plan under subdivision 8. a.~~ by June 30, 2015.

SECTION 20. Nonstatutory provisions.

(1) COVERAGE EXTENSION OF THE HEALTH INSURANCE RISK-SHARING PLAN; ISSUANCE OF MEDICARE SUPPLEMENT AND REPLACEMENT POLICIES.

(a) *Definitions.* In this subsection:

1. "Authority" means the Health Insurance Risk–Sharing Plan Authority under subchapter III of chapter 149 of the statutes.

2. "Commissioner" means the commissioner of insurance.

3. "Covered person" means a person who has coverage under the plan.

4. "Medicare" has the meaning given in section 149.10 (7) of the statutes.

5. "Medicare Advantage" has the meaning given in section INS 3.39 (3) (r), Wisconsin Administrative Code.

6. "Medicare replacement policy" has the meaning given in section 600.03 (28p) of the statutes.

7. "Medicare supplement policy" has the meaning given in section 600.03 (28r) of the statutes.

8. "Office" means the office of the commissioner of insurance.

9. "Plan" means the Health Insurance Risk–Sharing Plan under subchapter II of chapter 149 of the statutes.

(b) *Extension of the plan and authority.* Notwithstanding any statute, administrative rule, or provision of a policy or contract or of the plan to the contrary, the dissolution of the plan and the authority as provided in 2013 Wisconsin Act 20, section 9122 (1L), is modified as follows:

1. 'Coverage provisions.' Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., all of the following apply:

a. A covered person whose coverage under the plan was in effect on December 1, 2013, and who paid his or her December premium may elect to obtain a policy

insert 9-25 ✓

under the plan by making a timely payment of the January 2014 premium. The covered person must maintain the same policy benefits, including the same deductible amount, that were in effect on December 1, 2013. A new deductible period will commence on January 1, 2014. The premium for January 2014 must be paid no later than February 1, 2014. Thereafter, the covered person must pay premiums in accordance with the terms of the contract for coverage, which may not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the covered person incurs after December 31, 2013, and before the plan receives the premium payment for January 2014 shall be held in abeyance and the plan shall not be responsible for payment → until the premium payment is received ✓

****NOTE: I used "held in abeyance" instead of "pended." Will the plan pay for these claims after the premium is received? If so, it should be stated "until premium payment is received."

b. If a covered person's coverage under the plan is funded under a contract with the federal department of health and human services, the covered person's coverage will end as provided in 2013 Wisconsin Act 20, section 9122 (1L) (b) 1. b., unless the federal department of health and human services issues a contract amendment that extends the contract and coverage to a date later than December 31, 2013, and the terms of the contract amendment are such that the federal government will be financially liable for all costs related to the operation of the contract that exceed member premium collections.

c. If the requirements under subdivision 1. b. are satisfied, a covered person whose coverage is funded under a contract with the federal department of health and human services, whose coverage under the plan was in effect on December 1, 2013, who paid his or her December premium, and who had not enrolled in Medicare Advantage during the federal open enrollment period in 2013 ✓ or earlier may elect to

obtain a policy under the plan by making a timely payment of the January 2014 premium. The covered person must maintain the same policy benefits, including the same deductible amount, that were in effect on December 1, 2013. A new deductible period will commence on January 1, 2014. The premium for January 2014 must be paid no later than February 1, 2014. Thereafter, the covered person must pay premiums in accordance with the terms of the contract for coverage, which may not extend beyond 11:59 p.m. on March 31, 2014. Any medical claims that the covered person incurs after December 31, 2013, and before the plan receives the premium payment for January 2014 shall be held in abeyance and the plan shall not be responsible for payment. → until the premium payment is received ✓

****NOTE: I used "held in abeyance" instead of "pended." Will the plan pay for these claims after the premium is received? If so, it should be stated "until premium payment is received."

****NOTE: "During the open enrollment period in 2013 or earlier" is a bit vague. Is that limited to earlier *in 2013*?

d. No later than February 1, 2014, the authority shall provide notice that coverage shall terminate on March 31, 2014, to all covered persons, all insurers and providers that are affected by the termination of the coverage, the office, the legislative audit bureau, and the insurers described in paragraph (c) 1.

****NOTE: I thought it would be more relevant to the insurers in paragraph (c) in this subsection than to the insurers described in Act 20, section 9122 (1m).

2. 'Provider claims.' Providers of medical services and devices and prescription drugs to covered persons whose coverage is extended as provided in this paragraph must file claims for payment no later than June 1, 2014. Any claim filed after that date is not payable and may not be charged to the covered person who received the service, device, or drug. Except for copayments, coinsurance, or deductibles required under the plan, consistent with sections 149.14 (3) and 149.142 (2m) of the statutes, a provider may not bill a covered person who receives a covered service or article and

shall accept as payment in full the payment rate determined under section 149.142 (1) of the statutes.

****NOTE: I required claims to be filed, rather than received, by June 1, 2014. Please change this to received if that is what you intend. Since the date for filing is the same as for claims for services provided to persons whose coverage is not extended, I did not limit the claims to those for services provided after coverage is extended.

3. 'Grievances and review.'

a. Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 3. a., any grievance by a covered person whose coverage is extended as provided in this paragraph must be in writing and received by the plan no later than July 1, 2014, or be barred.

****NOTE: Since the date for submitting a grievance is extended for a person whose coverage is extended, do you want to limit the types of grievances that may be submitted up to that date, such as grievances arising after December 31, 2013?

b. Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 3. b., a covered person whose coverage is extended as provided in this paragraph who submits a grievance after March 31, 2014, must request an independent review, if any, with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review with respect to the grievance.

4. 'Payment of plan costs.'

a. To the extent possible, the authority shall pay plan costs incurred in 2013 and 2014 and all other costs associated with operating and dissolving the plan that are incurred before administrative responsibility for the dissolution of the plan is transferred to the office on February 28, 2014.

****NOTE: I removed the language about "requirements are met as provided in subsection (1L) (b) 8." because I didn't know what requirements were being referred to and what the relationship was to the rest of the sentence. If you want some language back in, please clarify the meaning.

b. Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 4., the authority, before March 1, 2014, and the office, on and after March 1, 2014, shall pay

plan costs in the manner provided in section 149.143 of the statutes, except that the authority or office may use all available surplus before imposing an assessment against insurers, as described in subdivision 4. c. All claims for payment shall be adjudicated by no later than September 30, 2014.

****NOTE: I added "for payment" after claims. By "all claims," I assume they include provider claims. If not, please clarify which claims are being referred to.

c. The authority, before March 1, 2014, and the office, on and after March 1, 2014, but by no later than July 1, 2014, shall determine whether an assessment of insurers under section 149.13 of the statutes is necessary to cover in full the plan's expenses related to operations, winding up operations, and dissolution of the plan. Such assessment shall be based on the 2013 filed plan assessment form.

****NOTE: Does just the determination have to be made, or does any assessment have to be imposed by no later than July 1, 2014?

5. 'Dissolution notice, claims, and updates.'

a. On behalf of the commissioner, the authority shall provide notice of the plan's dissolution to all persons known, or reasonably expected from the plan's records, to have claims against the plan, including all covered persons. Notwithstanding 2013 Wisconsin Act 20, section 9122 (1L) (b) 10. a., the notice shall be sent by 1st class mail to the last–known addresses no later than February 1, 2014. Notice to potential claimants of the plan shall require the claimants to file their claims, together with proofs of claims, by June 1, 2014. The notice shall be consistent with any relevant terms of the policies under the plan and contracts and with section 645.47 (1) (a) of the statutes. The notice shall serve as final notice consistent with section 645.47 (3) of the statutes.

b. Proofs of all claims must be filed with the office in the form provided by the office consistent with the proof of claim, as applicable, under section 645.62 of the

statutes, on or before the last day for filing specified in the notice. For good cause shown, the office shall permit a claimant to make a late filing if the existence of the claim was not known to the claimant and the claimant files the claim within 30 days after learning of the claim, but not later than September 1, 2014. Any such late claim that would have been payable under the policy under the plan if it had been filed timely and that was not covered by a succeeding insurer shall be permitted unless the claimant had actual notice of the termination of the plan or the notice was mailed to the claimant by 1st class mail at least 10 days before the insured event occurred.

(c) *Medicare supplement and replacement policy issuance.*

****NOTE: Are the people affected by this provision the same people described in paragraph (b) 1. b. and c. above? If so, all that is needed are the following provisions. I removed the proposed subdivision extending their HIRSP coverage because it is not needed if coverage has already been extended under paragraph (b) 1. b. and c. above. The provision in Act 20 that is similar to this was intended for the purpose of guaranteeing issue under Medicare supplement and replacement policies to persons eligible for Medicare whose coverage under HIRSP was ending. It was separate from the provisions related to terminating coverage under HIRSP and so this paragraph should not include any HIRSP coverage extension if it is intended to serve the same purpose. If I am mistaken and the people to whom this paragraph applies are not the same people described in paragraph (b) 1. b. and c. above, please let me know. There is no description of individuals in Act 20's subsection (1m) (b), however, as the proposed language suggested.

1. In addition to the requirement under 2013 Wisconsin Act 20, section 9122 (1m), an insurer offering a Medicare supplement policy or a Medicare replacement policy in this state shall provide coverage under the policy to any individual who satisfies all of the following:

a. The individual is eligible for Medicare.

b. The individual had coverage under the plan.

****NOTE: It should not be necessary to specify that the individual had coverage on December 1, 2013, because that is a requirement for extended coverage that ends on March 31, 2014, as provided in subdivision 1. c. below.

c. The individual's coverage under the plan terminated on March 31, 2014.

d. The individual applies for coverage under the policy before 63 days after the date specified in subdivision 1. c.

e. The individual pays the premium for the coverage under the policy.

2. An insurer under subdivision 1. may not deny coverage to any individual who satisfies the criteria under subdivision 1. a. to e. on the basis of health status, receipt of health care, claims experience, or medical condition including disability.

3. In addition to any other notice requirements to insurers, no later than February 1, 2014, the authority shall provide notice to the insurers described in subdivision 1. of the requirements under this paragraph.

SECTION 21. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTH INSURANCE RISK-SHARING PLAN. The treatment of section 895.514 (2) and (3) (a) and (b) of the statutes takes effect on January 1, 2015.

(END)

Insert
ED – TJD

"RESEARCH APPENDIX"

... Drafting History Reproduction Request Form ...

☞ **DRAFTING ATTORNEYS: PLEASE COMPLETE THIS FORM AND GIVE TO MIKE BARMAN**

(Request Made By: IJD) (Date: 11 / 26 / 2013)

Note:

BOTH DRAFTS SHOULD HAVE THE SAME "REQUESTOR"

(exception: companion bills)

Done MB

○ ☞ Please transfer the drafting file for

2011 LRB _____ (For: Rep. / Sen. _____)

to the drafting file for

2013 LRB _____ (For: Rep. / Sen. _____)

----------OR----------

Senate Version

○ ☞ Please copy the drafting file for

2013 LRB -3687 / 1 (include the version) (For: Rep. / Sen. Governor)

and place it in the drafting file for

2013 LRB -3678 (For: Rep. / Sen. Governor)

Assembly Version

☞ Are These "Companion Bills" ?? ... Yes No → but file "guts" each contain different material.

If yes, who in the initial requestor's office authorized the copy/transfer of the drafting history ("guts") from the original file: Same requestor

Updated: 09/05/2012

TJD Inserts

State of Wisconsin
2013 – 2014 LEGISLATURE

December 2013 Special Session

LRB-3687/P2
TJD:kjf&cjs:jm

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 49.471 (4m) and 49.67 (9m); ***to repeal and recreate*** 49.45 (23) (a), 49.45 (23) (a) and 49.471 (4) (a) 4. b. of the statutes; and ***to affect*** 2013 Wisconsin Act 20, section 9418 (7), 2013 Wisconsin Act 20, section 9418 (7m) and 2013 Wisconsin Act 20, section 9418 (9); **relating to:** delaying eligibility changes to BadgerCare Plus and BadgerCare Plus Core and delaying other changes to the Medical Assistance program.

Insert rel - TJD
and
(END Insert rel - TJD)

Analysis by the Legislative Reference Bureau

Insert Analysis - TJD
move
MEDICAL ASSISTANCE
Italics/bold (make title sub-sub head) LOST
L.C.

Currently, the Department of Health Services (DHS) administers the Medical Assistance (MA) program, which is a joint federal and state program that provides health services to individuals who have limited resources. Some services are provided through programs that operate under a waiver of federal Medicaid laws, including services provided through the BadgerCare Plus (BC+) and BadgerCare Plus Core (BC+ Core) programs. Under current law, BC+ provides health and medical services to eligible recipients and has a standard plan with a larger set of benefits and a Benchmark plan with fewer benefits. The 2013–2015 biennial budget act, 2013 Wisconsin Act 20 (Act 20), makes changes to BC+, BC+ Core, and MA, and some of those changes are not in effect until January 1, 2014.

Under current law, unless DHS has a policy that conflicts with current state law eligibility requirements, certain individuals are eligible for benefits under the BC+

Analysis - ED continued

standard plan. Beginning on January 1, 2014, Act 20 reduces the income eligibility level for the BC+ standard plan for parents and caretaker relatives from not more than 200 percent of the federal poverty line (FPL) to not more than 100 percent of the FPL before a 5 percent income disregard is applied. Act 20 also defines, beginning on January 1, 2014, for purposes of eligibility of a parent or caretaker relative, a "dependent child." In addition, Act 20 eliminates the distinction between self–employment income and other income. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

Under current law, certain individuals are eligible for benefits under the BC+ Benchmark plan including pregnant women whose family income exceeds 200 percent but does not exceed 300 percent of the FPL and children under one year of age of those women; certain other pregnant women; children whose family income exceeds 200 percent but does not exceed 300 percent of the FPL; and parents or caretaker relatives whose family income includes self–employment income and does not exceed 200 percent of the FPL under a certain calculation. Act 20, beginning on January 1, 2014, provides benefits under the standard plan to the pregnant women and children who are currently eligible for the BC+ Benchmark plan. Under Act 20, parents and caretaker relatives are covered only under the standard plan. Certain individuals, under current law, may pay the full member per month cost of coverage to receive benefits under the Benchmark plan. On January 1, 2014, Act 20 eliminates the ability of children whose family incomes exceed 300 percent of the FPL to receive Benchmark plan benefits. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

Under current law, BC+ Core provides basic primary and preventive care to eligible individuals. Adults who are under age 65, who have family incomes that do not exceed 200 percent of the FPL, and who are not otherwise eligible for MA, including BC+, are eligible for benefits under BC+ Core. Beginning January 1, 2014, Act 20 allows only those individuals whose family incomes do not exceed 100 percent of the FPL, before a 5 percent income disregard is applied, to be eligible for BC+ Core. Act 20 removes limitations on the benefits provided to individuals in BC+ Core and, thus, allows DHS to provide standard plan benefits to these individuals. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

Under current law, family income is the total gross earned and unearned income received by all members of a family. Beginning on January 1, 2014, under Act 20, for purposes of determining eligibility for BC+ and BC+ Core, family income has the meaning given for household income under a federal regulation, which uses an income calculation based on modified adjusted gross income. Act 20 also requires DHS, beginning on January 1, 2014, to apply the definition of household in federal regulations to determinations of income. Act 20 also makes other changes to the calculation of income and family size for BC+ and BC+ Core on January 1, 2014. This bill delays the effective date of these changes enacted in Act 20 from January 1, 2014, to April 1, 2014.

DHS also currently administers the BadgerCare Plus Basic (BC+ Basic) plan, which is not an MA program but is funded by premiums paid by plan participants.

Analysis TJD continued

To be eligible for the BC+ Basic plan, an individual must be on the waiting list for BC+ Core. BC+ Basic provides health care benefits that do not exceed those benefits provided by BC+ Core. Under current law, BC+ Basic terminates on January 1, 2014, and Act 20 repeals the BC+ Basic statutory language on that same date. The bill eliminates the statutory termination date and delays the repeal of BC+ Basic enacted in Act 20 until April 1, 2014.

Under current law, DHS is required to develop a purchasing pool, known as Badger Rx Gold, for pharmacy benefits and set eligibility requirements to obtain prescription drug coverage through the purchasing pool. Current law allows DHS to contract with an entity to operate the purchasing pool, which is not an MA program. Act 20 eliminates the purchasing pool, Badger Rx Gold, on January 1, 2014. The bill delays the elimination of Badger Rx Gold until April 1, 2014.

(End Insert Analysis-TJD)

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

Insert TJD-1

auto ref A

SECTION 1. 49.45 (23) (a) of the statutes, as affected by 2013 Wisconsin Act 20, section 1046, is repealed and recreated to read:

49.45 **(23)** (a) The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide health care coverage to adults who are under the age of 65, who have family incomes not to exceed 100 percent of the poverty line before application of the 5 percent income disregard under 42 CFR 435.603 (d), and who are not otherwise eligible for medical assistance under this subchapter, the Badger Care health care program under s. 49.665, or Medicare under 42 USC 1395 et seq. If the department creates a policy under sub. (2m) (c) 10., this paragraph does not apply to the extent that it conflicts with the policy.

auto ref B

SECTION 2. 49.45 (23) (a) of the statutes, as affected by 2013 Wisconsin Act 20, section 1047, and 2013 Wisconsin Act .... (this act), is repealed and recreated to read:

Insert TJD-1 continued

49.45 **(23)** (a) The department shall request a waiver from the secretary of the federal department of health and human services to permit the department to conduct a demonstration project to provide health care coverage to adults who are under the age of 65, who have family incomes not to exceed 100 percent of the poverty line before application of the 5 percent income disregard under 42 CFR 435.603 (d), and who are not otherwise eligible for medical assistance under this subchapter, the Badger Care health care program under s. 49.665, or Medicare under 42 USC 1395 et seq.

SECTION 3. 49.471 (4) (a) 4. b. of the statutes, as affected by 2013 Wisconsin Act 20, is repealed and recreated to read:

49.471 **(4)** (a) 4. b. The individual's family income does not exceed 100 percent of the poverty line before application of the 5 percent income disregard under 42 CFR 435.603 (d).

SECTION 4. 49.471 (4m) of the statutes, as created by 2013 Wisconsin Act 20, is repealed.

SECTION 5. 49.67 (9m) of the statutes is repealed.

(End Insert TJD-1)

Insert TJD-2

SECTION 6. 2013 Wisconsin Act 20, section 9418 (7) is amended to read:

[2013 Wisconsin Act 20] Section 9418 (7) PATIENT PROTECTION AND AFFORDABLE CARE ACT CHANGES. The treatment of sections 49.45 (23) (a) (by SECTION 1046), ~~(b) (by SECTION 1048),~~ and (e), 49.46 (1) (a) 15., 49.47 (4) (a) 1. ~~and (c) 1. and 3.~~, 49.471 (1) (f), ~~(2),~~ (3) (a) 1. and 3., (4) (a) 4. a., b., and c., ~~and 5.~~ and (b) (intro.), 1., 1m., 2., 3., and 4., (6) (d), (7) (a), (b) 1. and 2. and (e), (8) (d) 1. b., (9) (a) 2. b., and (10) (b) 1. (by SECTION 1143) and 4. b., 49.84 (6) (c) 1. d., and 66.0137 (3) of the statutes, the repeal of section 49.471 (7) (c) of the statutes, and SECTION 9318 (14) of this act take effect on ~~January~~ April 1, 2014.

Insert TJD-2 continued

SECTION 7. 2013 Wisconsin Act 20, section 9418 (7m) is created to read:

[2013 Wisconsin Act 20] Section 9418 (7m) CHILDLESS ADULT WAIVER; MEDICAL ASSISTANCE FOR THE MEDICALLY INDIGENT; ELIGIBILITY FOR THOSE LEAVING FOSTER CARE. The treatment of sections 49.45 (23) (b) (by SECTION 1048), 49.47 (4) (c) 1. and 3., and 49.471 (2) and (4) (a) 5. of the statutes takes effect on January 1, 2014.

SECTION 8. 2013 Wisconsin Act 20, section 9418 (9) is amended to read:

[2013 Wisconsin Act 20] Section 9418 (9) BADGERCARE PLUS BENCHMARK ELIGIBILITY; BADGER RX GOLD; BADGERCARE BASIC. The treatment of sections 20.435 (4) (a), (bm), (jw), and (jz), 49.471 (4) (c), (10) (b) 5. (by SECTION 1152), and (11) (a), 49.67, 146.45, 227.01 (13) (ur), and 227.42 (7) of the statutes takes effect on ~~January~~ April 1, 2014.

(END INSERT TJD-2)

SECTION ~~9~~. Effective dates. This act takes effect on the day after publication, ~~except as follows:~~

(CS) MEDICAL ASSISTANCE ELIGIBILITY

Insert ED-TJD (4) #8

(1) The treatment of sections 49.45 (23) (a) (by SECTION 1) and 49.471 (4) (a) 4. b. of the statutes takes effect on April 1, 2014.

auto ref A — (check autorefs)

(4) #9

(2) The treatment of section 49.45 (23) (a) (by SECTION 2) of the statutes takes effect on January 1, 2015.

auto ref B

RECONCILIATION WITH 2011 WISCONSIN ACT 32

(END)

(CS) (END INSERT ED-TJD)

INSERT A–PJK 183

Dissolution of the Health Insurance Risk–Sharing Plan

The Health Insurance Risk–Sharing Plan (HIRSP), which is administered by the Health Insurance Risk–Sharing Plan Authority (authority), provides health insurance coverage in individual policies for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, and persons (called "eligible individuals" in the statutes) who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage (creditable coverage) for at least 18 months in the past. HIRSP is funded by premiums paid by covered persons, insurer assessments, and provider payment discounts.

Current law provides for the dissolution of HIRSP and the authority. Generally, coverage under HIRSP may not be issued to any person after December 1, 2013, existing coverage under HIRSP will end on January 1, 2014, or on the date that any health insurance coverage that is accessed through an American health benefit exchange in this state is effective, if that is later than January 1, 2014, and the authority must pay the costs of HIRSP that are incurred before administrative responsibility for HIRSP and HIRSP's remaining cash assets, tangible personal property, contracts and agreements, and all other matters, including grievances and independent reviews, are transferred to the Office of the Commissioner of Insurance (OCI). Thereafter, OCI must take any action necessary or advisable to wind up the affairs of HIRSP.

Extension of coverage under the Health Insurance Risk–Sharing Plan

The bill makes various modifications to the timetable for the dissolution of HIRSP, including the following:

1. Under the bill, all coverage under HIRSP terminates at 11:59 p.m. on December 31, 2013, but an individual who has coverage on December 1, 2013, and who has paid the December premium may elect to obtain a policy under HIRSP by making a timely payment of the January 2014 premium. Any such new policy must have the same benefits, including the deductible amount, that were in effect on December 1, 2013, and may not extend beyond March 31, 2014. An individual who is eligible for Medicare has the same option to extend coverage under a HIRSP policy until March 31, 2014, if the individual was covered under HIRSP on December 1, 2013, has paid the December premium, did not enroll in Medicare Advantage during the federal open enrollment period in 2013, and, for individuals whose coverage is funded under a contract with the federal department of health and human services, the federal department of health and human services takes certain actions. *

2. Under current law, provider claims for payment for medical services provided to individuals with coverage under HIRSP must be filed no later than 90 days after coverage terminates or they will not be paid. Under the bill, all provider claims for services provided to HIRSP enrollees must be filed no later than June 1,

Ins A-PJK cont'd 2 of 3

2014, or they will not be paid. All provider claims must be adjudicated by September 30, 2014.

3. Under current law, a grievance must be submitted no later than 180 days after coverage terminates or be barred, and an independent review must be requested no later than 60 days after the individual receives notice of the disposition of his or her grievance. The bill provides that a grievance must be received no later than July 1, 2014, or be barred, and that an individual who submits a grievance after March 31, 2014, must request an independent review with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review.

4. Under current law, the transfer from the authority to OCI of administrative responsibility for HIRSP and HIRSP's remaining cash assets, tangible personal property, contracts and agreements, and all other matters takes place 60 days after coverage under HIRSP terminates. Under the bill, the transfer takes place on February 28, 2014.

5. Under current law, the authority must pay HIRSP's costs incurred in 2013 and those that are incurred before the transfer to OCI. The authority must make every effort to pay costs in accordance with the manner provided in the statutes, which is that costs are to be paid 60 percent from premiums, 20 percent from insurer assessments, and 20 percent from adjustments to provider payments. Under the bill, the authority before March 1, 2014, and OCI on and after March 1, 2014, must pay all of HIRSP's costs in accordance with the manner provided in the statutes, except that any available surplus may be used before an assessment is imposed against insurers. OCI must determine no later than July 1, 2014, whether an insurer assessment is necessary.

Time–limited guaranteed issue under Medicare supplement and replacement policies

Under current law, an insurer that offers a Medicare supplement or replacement policy must provide coverage to any individual who is eligible for Medicare, who had coverage under HIRSP, whose coverage terminates on January 1, 2014, or on the date that any health insurance coverage that is accessed through an American health benefit exchange in this state is effective, if that is later than January 1, 2014, who applies for coverage before 63 days after their coverage terminated, and who pays the premium. Coverage may not be denied on the basis of health status, receipt of health care, claims experience, or medical condition. Under the bill, the requirement to provide coverage applies if the individual's coverage under HIRSP terminated on December 31, 2014, which is the new date for coverage termination under the bill. In addition, the bill imposes the same requirement on an insurer that offers a Medicare supplement or replacement policy to provide coverage under such a policy to an individual who is eligible for Medicare, whose coverage under HIRSP terminates on March 31, 2014, who applies for

Ins A-PJK cont'd 3 of 3

coverage under the Medicare supplement or replacement policy before 63 days after their coverage terminated, and who pays the premium.

FE-S

(END OF INSERT A–PJK)

INSERT 6–16

3. a. Except for a grievance related to a prior authorization, any grievance by a covered person must be in writing and received no later than July 1, 2014, or be barred.

c. A covered person who submits a grievance after March 31, 2014, must request an independent review, if any, with respect to the grievance no later than August 1, 2014, or be barred from requesting an independent review with respect to the grievance.

(END OF INSERT 6–16)

INSERT 9–25

, and who, if eligible for Medicare, had not enrolled in Medicare Advantage during the federal open enrollment period in 2013

(END OF INSERT 9–25)

Insert 2 – 14

and shall not exceed 100 percent.

SECTION 1. 71.07 (5g) (c) 1. of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.07 **(5g)** (c) 1. The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under par. (b) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.28 (5g), 71.47 (5g), and 76.655 for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

History: 1987 a. 312; 1987 a. 411 ss. 63, 79 to 82, 85, 86; 1987 a. 419, 422; 1989 a. 31, 44, 56, 100, 359; 1991 a. 39, 269, 292; 1993 a. 16, 112, 204, 471, 491; 1995 a. 27 ss. 3377m to 3393m, 9116 (5); 1995 a. 209, 227, 400, 453; 1997 a. 27, 41, 237, 299; 1999 a. 5, 9, 10, 32; 1999 a. 150 s. 672; 1999 a. 198; 2001 a. 16, 109; 2003 a. 72, 99, 135, 183, 255, 267, 326; 2005 a. 25, 49, 72, 74, 97, 177, 254, 361, 387, 479, 483, 487; 2007 a. 11, 20, 96, 97, 100; 2009 a. 2, 11, 28, 180, 185, 265, 267, 269, 276, 294, 295, 332, 401; 2011 a. 15, 32, 67, 212, 213, 232, 237; 2011 a. 260 s. 80; 2013 a. 20 54; s. 35.17 correction in (2dr) (a), (5n) (a) (intro.).

Insert 3 – 3

SECTION 2. 71.28 (5g) (c) 1. of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.28 **(5g)** (c) 1. The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under par. (b) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the

and shall not exceed 100 percent.

percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.07 (5g), 71.47 (5g), and 76.655 for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

(end ins 3-3)

History: 1987 a. 312; 1987 a. 411 ss. 88, 130 to 139; 1987 a. 422; 1989 a. 31, 44, 56, 100, 336, 359; 1991 a. 39, 292; 1993 a. 16, 112, 232, 491; 1995 a. 2; 1995 a. 27 ss. 3399r to 3404c, 9116 (5); 1995 a. 209, 227; 1997 a. 27, 41, 237, 299; 1999 a. 5, 9; 2001 a. 16; 2003 a. 72, 99, 135, 255, 267, 326; 2005 a. 25, 74, 97, 361, 387, 452, 479, 483, 487; 2007 a. 20, 96, 97, 100; 2009 a. 2, 11, 28, 180, 185, 265, 267, 269, 276, 294, 295, 332, 401; 2011 a. 3, 15, 32, 67, 212, 213, 232, 237; 2011 a. 260 s. 80; 2013 a. 20, 54; s. 35.17 correction in (1dm) (a) 1.

Insert 3 – 17

SECTION 3. 71.47 (5g) (c) 1. of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

71.47 **(5g)** (c) 1. The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under par. (b) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.07 (5g), 71.28

and shall not exceed 100 percent.

(5g), and 76.655 for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

(end ins 3-17)

History: 1987 a. 312, 411, 422; 1989 a. 31, 44, 56, 100, 336, 359; 1991 a. 39, 292, 315; 1993 a. 16, 112; 1995 a. 27 ss. 3407m to 3412m, 9116 (5); 1995 a. 209, 227, 417; 1997 a. 27, 41, 237, 299; 1999 a. 5, 9; 2001 a. 16; 2003 a. 72, 99, 135, 255, 267, 326; 2005 a. 25, 74, 97, 361, 387, 452, 479, 483, 487; 2007 a. 20, 96, 97, 100; 2009 a. 2, 11, 28, 180, 185, 265, 267, 269, 276, 294, 295, 332, 401; 2011 a. 3, 15, 32, 67, 212, 213, 232, 237; 2011 a. 260 ss. 80, 81; 2013 a. 20.

Insert 4 – 6

SECTION 4. 76.655 (3) (a) of the statutes, as affected by 2013 Wisconsin Act 20, is amended to read:

76.655 **(3)** (a) The department of revenue, in consultation with the office of the commissioner of insurance, shall determine the percentage under sub. (2) for each claimant for each taxable year. The percentage shall be equal to $5,000,000 divided by the aggregate assessment under s. 149.13, 2011 stats., except that for taxable years beginning after December 31, 2013, and before January 1, 2015, the percentage shall be equal to $1,250,000 divided by the aggregate assessment under s. 149.13, 2011 stats. The office of the commissioner of insurance shall provide to each claimant that participates in the cost of administering the plan the aggregate assessment at the time that it notifies the claimant of the claimant's assessment. The aggregate amount of the credit under this subsection and ss. 71.07 (5g), 71.28 (5g), and 71.47 (5g) for all claimants participating in the cost of administering the plan under ch. 149, 2011 stats., shall not exceed $5,000,000 in each fiscal year.

History: 2005 a. 74; 2013 a. 20.

; and shall not exceed 100 percent.

Barman, Mike

From: LRB.Legal
Sent: Tuesday, November 26, 2013 8:30 AM
To: Hurlburt, Waylon - GOV
Subject: RE: Draft Review: LRB -3678/1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus

I will jacket this for you right away ... it will be available for pick-up at our front counter.

Thanks,

Mike Barman (**Lead Program Assistant**)
State of Wisconsin - Legislative Reference Bureau - Legal Section - Front Office
1 East Main Street, Suite 200, Madison, WI 53703
(608) 266-3561 / mike.barman@legis.wisconsin.gov

From: Hurlburt, Waylon - GOV [mailto:Waylon.Hurlburt@wisconsin.gov]
Sent: Tuesday, November 26, 2013 8:25 AM
To: LRB.Legal
Cc: Kahler, Pam; Dodge, Tamara
Subject: Draft Review: LRB -3678/1 Topic: Delay for three months the dissolution of HIRSP and the changes to BadgerCare Plus

Please Jacket LRB -3678/1 for the ASSEMBLY.

State of Wisconsin
LEGISLATIVE REFERENCE BUREAU

☞Appendix A

LRB BILL HISTORY RESEARCH APPENDIX

☞ The drafting file for 2013 LRB–3678/1 (For: Governor)

has been copied/added to the drafting file for

2013 LRB–3687 (For: Governor)

☞ Are These "Companion Bills" ?? ... Yes

* These are companion bills but each drafting file contains material not contained in the other.

RESEARCH APPENDIX -

PLEASE KEEP WITH THE DRAFTING FILE

Date Transfer Requested: 11/26/2013 (Per: TJD)

☞ The attached draft was incorporated into the new draft listed above. For research purposes the attached materials were added, as a appendix, to the new drafting file. If introduced the section will be scanned and added, as a separate appendix, to the electronic drafting file folder.